Budget Initiative Fact Sheet

Office: **MaineCare Services** **Date:** **12/13/2011**

Initiative #: **7430 – Consumer Directed Attendant Services**

Account: **0147**

I. Budget Proposal Description:

This initiative proposes to eliminate consumer directed attendant services (MaineCare Benefits Manual, Section 12) as an optional service.

Consumer Directed Attendant Services provide medically necessary services directed by the member such as personal care, care coordination and skills development to MaineCare members age 18 or older and physically disabled.

II. Financial Information:

	SFY'08	SFY'09	SFY'10	SFY'11
General Fund	1,003,848	1,005,986	1,244,947	1,775,384
Other Special Revenue				
Federal Funds	1,731,323	2,418,065	3,652,110	4,742,245
Total	2,735,171	3,424,051	4,897,057	6,517,629

Other sources of funding for program, i.e. FHM? Yes **X** No

III. Total users of service:

SFY 2008 Unduplicated Members	*SFY 2009 Unduplicated Members*	*SFY 2010 Unduplicated Members*	*SFY 2011 Unduplicated Members*
449	*643*	*749*	*2,972*

*User data has changed from SFY '10 to SFY '11 due to enrollment and billing under MIMHS. Previously, in SFY '10 there were local codes that distinguished service rendered and where service was delivered. In the transition to MIMHS we are using HIPAA compliant codes and pulling data based on these codes which includes all services provided.

IV. Program Eligibility Criteria:

- Members meet the medical eligibility requirements if they require a combination of assistance with the required Activities of Daily Living (ADL), as defined in Section 12.03-1(D)

- The member must have a disability with functional impairments that interfere with the member's own capacity to provide self-care and daily living skills without assistance. The member's disability must be permanent or chronic in nature as verified by the member's physician.

- A registered nurse trained in conducting assessments with the Department's approved MED form must conduct the medical eligibility assessment. The assessor must, as appropriate within the practice of professional nursing judgment, consider documentation, perform observations and conduct interviews with the applicant/member, family members, direct care staff, the applicant's/member's physicians and other individuals and document in the record of the assessment all information considered relevant in his or her professional judgment. The following levels of eligibility are determined at assessment:

  Level I A member meets the medical eligibility requirements for Level I if he or she requires at least limited assistance plus a one person physical assist with at least two (2) of the following ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

  Level II A member meets the medical eligibility requirements for Level II if he or she requires at least limited assistance and a one person physical assist with at least three (3) of the following ADLs: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

  Level III A member meets the medical eligibility requirements for Level III if he or she requires at least extensive assistance and a one-person physical assist with two of the following five ADLs: bed mobility, transfer, locomotion, eating, or toileting; and limited assistance and a one-person physical assist with two of the following additional ADLS: bed mobility, transfer, locomotion, eating, toilet use, dressing, and bathing.

  - The member must agree to complete initial member instruction and testing within 30 days of completion of the MED form to determine medical eligibility in order to develop and verify that he or she has attained the skills needed to hire, train, schedule, discharge and supervise attendants and document the provision of personal care services identified in the authorized plan of care. Members who do not complete the course of instruction or do not demonstrate to the Service Coordination Agency that they have attained the skills needed to self-direct are not eligible for services under this Section;

  - The member must not be residing in a hospital, nursing facility, or Intermediate Care Facility for the Mentally Retarded (ICF-MR) as an inpatient;

  - The member must not reside in an Adult Family Care Home (as defined in MaineCare Benefits Manual, Chapters II and III, Section 2,) or other residential setting including a Private Non-Medical Institution (MBM, Chapters II and III, Section 97), sometimes referred to as a residential care facility or supported living, regardless of payment source, (i.e. private or MaineCare);

  - The member must not be receiving personal care services under Private Duty Nursing/Personal Care Services, or be receiving any In-home community and support services for elderly and other adults, Section 63, or participating in other MaineCare programs where personal care services are a covered service.

  - The member must have the cognitive capacity, as measured on the MED form to be able to "self-direct" the attendant. The ASA will assess cognitive capacity as part of each member's

eligibility determination using the MED findings. The Service Coordination Agency will assess cognitive capacity as part of consumer instruction. Minimum MED form scores are:

1. Decision- making skills: a score of 0 or 1;
2. Making self-understood: a score of 0, 1, or 2;
3. Ability to understand others: a score of 0, 1, or 2;
4. Self-performance of managing finances: a score of 0, 1,or 2; and
5. Support for managing finances, a score of 0, 1, 2, or 3.

- An applicant not meeting the specific scores above during his or her eligibility determination will be presumed not able to self-direct and ineligible for benefits under this Section.

- Applicants who meet these eligibility criteria for personal care attendant services shall:

i. Receive an authorized plan of care based upon the scores, timeframes, findings and covered services recorded in the MED assessment. The covered services to be provided in accordance with the authorized plan of care must not exceed the established limits and must be authorized by the Department or its ASA;

ii. The ASA must approve an eligibility period for the member, based upon the scores, timeframes and needs identified in the MED assessment for the covered services, and the assessor's clinical judgment. An eligibility period cannot exceed 12 months;

iii. The ASA forwards the completed assessment packet to the Service Coordination Agency of the Member's choice within three business days of the medical eligibility determination and authorization of the plan of care;

iv. The Service Coordination Agency must contact the member within 24 hours of receipt of the MED assessment and authorized plan of care. The Service Coordination Agency must implement skills training and coordinate services with the Member as well as monitor service utilization and assure compliance with this policy; and

v. The Service Coordination Agency will complete the service plan and initiate skills instruction within 30 days of the medical eligibility assessment date. The Service Coordination Agency will notify the Department, using the transmittal form approved by the Department, when the member has successfully completed this requirement and an attendant has been hired. Provision of attendant services can begin only after the Department is notified that the Member has successfully completed this training and the service plan has been received.

V. Current Budget Proposal:

1) Appropriation Increase: $ -0-

	SFY '12	SFY '13
2) Appropriation Decrease:	$ 449,605	2,440,130

3) Savings/Reduction Plan: Eliminate this optional coverage eliminating consumer directed attendant services as an optional service.

Services: Care Coordination, Skills Development, Personal Care Services

4) Any contracts impacted? ☐ Yes x No

VI. Legal Requirements:

Federal – subject to approval of CMS State Plan Amendment. Members and providers must receive notification in advance. Medically necessary services for children are required through EPSDT and may not be eliminated.

State – subject to approval of state rulemaking and changes to statute 22 MRSA §3174-Q.

VII. Maintenance of Effort Requirements? ☐ Yes X No

VIII. Procedures Performed and Billed to MaineCare by Code Number:

Procedure Code	Procedure	Count of Procedure
G9001	MCCD, Initial Rate	12
G9002	MCCD, Maintenance Rate	39,306
H2014	Skills Train & Dev, 15 Min	5,848
S5125	Attendant Care Service /15m	88,016
Grand Total		**133,182**

IX. Demographic Information: (2010 Data)

COUNTY	COUNT(DISTINCTPERSON_ID)
Androscoggin	52
Aroostook	109
County Unidentified	22
Cumberland	69
Franklin	15
Hancock	20
Kennebec	105
Knox	10
Lincoln	8
Oxford	15
Penobscot	128
Piscataquis	33
Sagadahoc	24
Somerset	35
Waldo	10
Washington	55
York	39

Gender	
Female	475
Male	274

Between Age 55 -64	178
Average Age	52
Median Age	52

Marital Status	
Divorced	143
Married	101
Single	320
Widowed	55
Separated	37
Unidentified	93

Income	
Earnings	21
Pension/Retirement	16
Unemployment	2
Workers Comp	2